TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER kkk : HEALTH CARE SERVICE PLANS

PART 5420
MANAGED CARE REFORM & PATIENT RIGHTS

Section

AUTHORITY: Implementing the Managed Care Reform and Patient Rights Act [215 ILCS 134/1 through 299] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401].

SOURCE: Emergency rules adopted at 23 Ill. Reg. 12466, effective September 27, 2000, for a maximum of 150 days; adopted at 24 Ill. Reg. 3374, effective February 10, 2000; amended at 24 Ill. Reg. 9429, effective July 1, 2000.

Section 5420.10 Purpose

This Part will implement Public Act 91-617, the Managed Care Reform and Patient Rights Act in order to assure: the proper provision of information to enrollees by health care plans; the proper treatment of enrollees by health care plans; the proper treatment of health care providers by health care plans; and the proper oversight of health care plans by the Department of Insurance.

Section 5420.20 Applicability

a) All provisions of this Act are applicable to the Comprehensive Health Insurance Plan, Health Maintenance Organizations, Voluntary Health Service Organizations, and Limited Health Service Organizations except those plans offering only dental services or only vision services. In addition, Sections 55 and 85 of the Act are applicable to Third Party Administrators. Also Sections 55 and 85 of the Act, as well as compliance with the definition of the term emergency medical condition, as defined in Section 10 of the Act, are applicable to entities regulated under Article XX ½ of the Insurance Code, generally referred to as Preferred Provider Organizations. Finally, Section 85 of the Act and compliance with the definition of the term "emergency medical condition" as defined in Section 10 of the Act are applicable to all insurers authorized to transact the sale of accident and health insurance in Illinois.

b) Until July 1, 2000, health care plans may, but are not required to, incorporate the transition of service standards defined in Section 5420.60 of this Part and also referred to in Section 5420.40 and 5420.50 of this Part.

Section 5420.30 Definitions

Act means the Managed Care Reform and Patient Rights Act [215 ILCS 134/1 through 299].

Code means the Illinois Insurance Code including any of the Acts in Chapter 215 of the Illinois Compiled Statutes.

Department means the Illinois Department of Insurance.

Director means the Director of the Illinois Department of Insurance.

Health Care Plan means a plan that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan. For purposes of this definition, "health care plan" shall not include the following: (1) indemnity health insurance policies including those using a contracted provider network; (2) health care plans that offer only dental or only vision coverage; (3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code; (4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974; (5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and (6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

Health Care Provider means any physician, hospital facility, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in the Act shall be construed to define independent practice associations or physician hospital organizations as health care providers.

Long-Standing Relationship means the continuous relationship between an enrollee and his or her primary care physician of not less than 5 years; except in the case of a child 5 years or under who has had a continuous relationship with the

same primary care physician since birth, placement for adoption, guardianship or foster care.

Managed Care Organization (MCO) means a partnership, association, corporation or other legal entity, including but not limited to individual practice associations (IPAs) and Physician Hospital Organizations (PHOs), which delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish such health care services.

Ongoing Course of Treatment means the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a physician because of the potential for changes in the therapeutic regimen.

Person means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

Referral Arrangement means that for each referral or standing referral, a referral arrangement exists between a participating primary care physician and a participating specialist physician or a participating health care provider when a participating primary care physician makes a referral of an enrollee for that referral or standing referral to a participating specialist physician or participating health care provider.

Standing Referral means a written referral from the primary care physician for an ongoing course of treatment pursuant to a treatment plan specifying needed services and time frames developed by a specialist in consultation with the primary care physician and in accordance with procedures developed by the health care plan.

Utilization Review means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Utilization Review Organization means an entity that has established one or more utilization review program. This definition does not include:

persons providing utilization review program services only to the federal government;

self-insured health plans under the Federal Employee Retirement Income Security Act of 1974 (ERISA); however, this Part does apply to persons conducting a utilization review program on behalf of these health plans;

hospitals and medical groups performing utilization review activities for internal purposes; however, this Part does apply when the hospital or medical group is conducting utilization review for another person.

Utilization Review Program means a program established by a person to perform utilization review.

(Source: Amended at 24 Ill. Reg. 9429, effective July 1, 2000)

Section 5420.40 Provision of Information

a) Description of Coverage

1) So that a person can compare the attributes of various health care plans, both a description of coverage cover page and worksheet must be completed by the health care plan. The cover page and worksheet shall follow substantially the same format as prescribed in Exhibits A and B respectively of this Part. Each shall be printed in no less than 12 point type.

A) Copayments and/or deductibles which vary within a specific benefit category must be listed individually for each item (e.g., copayments for prescription drugs should be listed separately based upon the drug being brand name or generic equivalent).

B) The category entitled "Other Services" may be modified to include additional headings as may be appropriate. If the contract does not provide coverage for listed "Other Services", the description of coverage worksheet should so indicate by stating "Not Applicable" for each such item.

C) A health care plan specific description of coverage worksheet shall contain financial information specific to the enrollee's plan. A generic description of coverage worksheet will be applicable to all of the health care plan's plans and include a general description of financial information.

D) All description of coverage worksheets shall include a notice of the enrollee's right to request a description of the financial relationships between the health care plan and any health care provider, the percent of copayments, deductibles and total premiums spent on health care related and administrative expenses, as well as a notice of the enrollee's right to request health care provider information from their provider as set forth in Section 15(c) of the Managed Care Reform and Patient Rights Act.

E) All description of coverage worksheets shall clearly disclose that referral arrangements through the enrollee's participating primary care physician may limit the enrollee's ability to seek services from

certain participating specialist physicians or participating health care providers. To obtain clarification on such referral arrangements, the enrollees must be instructed to contact their participating primary care physician's office. If a referral arrangement does not exist between the enrollee's participating primary care physician and the desired participating specialist physician or participating health care provider, then the enrollees must be informed of their ability to designate a new participating primary care physician with whom such referral arrangement does exist.

F) The description of coverage worksheet for point of service products, defined within 50 Ill. Adm. Code 5421.20, must include a specific description of coverages, limitations, exclusions, deductibles and copayments specific to the indemnity contract.

2) A plan specific description of coverage cover page, worksheet and a list of participating health care providers shall be given to all new enrollees. Annually thereafter, a generic description of coverage cover page and worksheet must be mailed to enrollees. Only one enrollee per household must be furnished this material unless otherwise requested by the enrollee. For group contracts, the plan may satisfy this requirement by giving the required material to the contract holder, for distribution to their members.

3) Enrollees must be advised annually of their right to request a plan specific description of coverage cover page, worksheet and an updated list of participating health care providers. The enrollee shall be given the choice of requesting this information through a local telephone number or long distance toll-free telephone number and a prepaid postcard.

4) The plan specific description of coverage cover page, worksheet and list of participating health care providers shall be given to all prospective enrollees upon request. Availability of this information shall be prominently communicated within the health care plan's marketing materials. Prospective enrollees shall be able to request this information through a local telephone number or a long distance toll-free telephone number.

5) Health care plans are encouraged to make a generic description of coverage cover page, worksheet and list of participating health care

providers available on their web sites. This will not act as a substitute for other forms of required disclosure.

6) Health care plans issuing contracts or evidences of coverage for delivery in this State shall not issue such contract or evidence of coverage unless a specific description of coverage cover page and worksheet are provided.

7) All health care plans must clearly communicate their procedure for the filing of complaints pursuant to Section 45 of the Act. When a health care plan is permitted by statute to require complaints be filed in writing, the appropriate complaint form must be made available to the enrollee.

b) Within the group contract, evidence of coverage, individual contract and enrollee handbook, the health care plan shall provide a notice of the enrollees' right to request a description of the financial relationships between the health care plan and any health care provider, the percent of copayments, deductibles and total premiums spent on health care related and administrative expenses as well as the right to obtain health care provider information from their provider as set forth in Section 15(c) of the Managed Care Reform and Patient Rights Act.

c) Each health care plan shall clearly disclose, within the group contract, evidence of coverage, individual contract, enrollee handbook and provider directory that referral arrangements through the enrollee's participating primary care physician may limit the enrollee's ability to seek services from certain participating specialist physicians or participating health care providers. To obtain clarification on such referral arrangements, the enrollees must be instructed to contact their participating primary care physician's office. If a referral arrangement does not exist between the enrollee's participating primary care physician and the desired participating specialist physician or participating health care provider, then the enrollee must be informed of his ability to designate a new participating primary care physician with whom such referral arrangement does exist.

d) Within the group contract, evidence of coverage, individual contract and enrollee handbook, all health care plans must clearly communicate their procedure for the filing of complaints pursuant to Section 45 of the Act. When a health care plan is permitted by statute to require complaints be filed in writing, the appropriate complaint form must be made available to the enrollee.

Section 5420.50 Notice of Nonrenewal or Termination

a) All provider agreements shall provide for at least 60 days notice by the provider for termination with cause, as defined in such provider agreement, and at least 90 days notice by the provider for termination without cause. In the event the provider violates the provider agreement and does not give a notice of termination in the appropriate timeframe, the health care plan must provide immediate notice to the enrollees. The health care plan must inform the Department immediately of any known or intended termination, with or without cause, of an MCO.

b) A health care plan must give at least 60 days notice of nonrenewal or termination of a health care provider to the health care provider and to the enrollees served by the health care provider. The notice shall include a name and address to which an enrollee or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a State licensing board. The notice shall inform the enrollee of the availability of transitional services and that the enrollee must request transitional services within 30 days from receipt of this notice.

Section 5420.60 Transition of Services

a) Health care plans shall notify new enrollees and current enrollees of the availability of transitional services for conditions that require ongoing course of treatment.

b) New enrollees must request the option of transitional services in writing, within 15 days after receiving notification of the availability of transitional services, through a mechanism established by the health care plan.

c) Enrollees whose physician leaves the health care plan’s network of health care providers shall request the option of transitional services in writing within 30 days after receipt of notification of termination of the physician.

d) Within 15 days after receiving such notification from the enrollee, the health care plan shall notify the enrollee if a denial is issued for the enrollee’s request of transitional services based on the enrollee's physician refusing to agree to accept the health care plan's reimbursement rates, adhere to the health care plan's quality assurance requirements, provide the health care plan with necessary medical information related to the enrollee's care, or otherwise adhere to the health care plan's policies and procedures. The notification shall be in writing and include the specific reason for such denial.

Section 5420.70 Health Care Services, Appeals, Complaints and External Independent Reviews

Every health care plan shall submit for the Department's review, and thereafter maintain, a mechanism for the joint selection of the external independent reviewer. Any proposed changes to the mechanism must be filed for review by the Department.

Section 5420.80 Joint Resolution of Complaints - Department of Insurance and Department of Public Health - Notification and Resolution Process

a) Complaints against health care plans participating in programs administered by the Department of Public Aid pursuant to the Public Aid Code shall be resolved under rules published by the Department of Public Aid. Any complaints against such plans received by the Department of Insurance or the Department of Public Health shall be referred to the Department of Public Aid.

b) Any enrollee or health care provider, on behalf of the enrollee, may file a written complaint against the health care plan through the Department of Insurance. Complaints received by the Department of Public Health shall be referred to the Department of Insurance for processing prior to investigation.

c) The health care plan response shall include documentation and an explanation of all actions taken or not taken that were the basis for the complaint. The respondent shall include documents necessary to support the respondent's position and any additional information requested by the Department of Insurance and/or the Department of Public Health. Both the Department of Insurance and the Department of Public Health shall maintain confidentiality of medical records and other pertinent documents.

d) Quality of care complaints may be referred to the Department of Public Health for investigation.

1) The Department of Public Health shall determine if an on-site investigation is warranted and may request additional information from the complainant, health care provider, or health care plan if the information provided is determined to be incomplete or if additional information is needed to make a determination regarding the complaint.

2) If an investigation is warranted, the Department of Public Health shall make available the name, address and telephone number where an enrollee may obtain the status of the complaint.

3) The Department of Public Health shall forward the findings of the investigation to the Department for final disposition and record keeping.

e) No Department of Insurance or Department of Public Health publication or release of information shall identify any enrollee, health care provider, or individual complainant.

Section 5420.90 Record of Complaints

a) Complaint, as used in this Section, means any communication primarily expressing a grievance to the health care plan by, or on behalf of, the enrollee, or by the health care provider. For purposes of this definition, "communication" shall include the following:

1) A written notice relating to the health care plan's determinations, procedures and administration as stated in Sections 45 and 50 of the Act; and

2) Written or oral notice filed under the expedited health care services appeal process or under the utilization review process.

b) The health care plan shall submit to the Director a report by March 1 for the previous calendar year which shall include a record of complaints in the format prescribed in Exhibit C of this Part.

Section 5420.100 Access and Quality of Care from Providers Without Primary Care Physician Referral or Authorization

a) Health care plans that allow enrollees to access health care services from contractual providers without a referral or authorization from the primary care physician (PCP) shall have in place a system for centralized record keeping to track and monitor the provider/enrollee encounters to assure that enrollees are receiving needed services.

b) The health care plan's centralized record keeping system for access and quality of care shall be described in detail, filed with and deemed acceptable by the Director of Public Health. The Director of Public Health shall forward a copy of the approved system for record keeping and the notice of his final action with the Department of Insurance.

c) The health care plan shall be able to retrieve an enrollee's centralized record of the provider/enrollee encounters for review by the Department and/or Department of Public Health as part of a complaint investigation or inquiry.

Section 5420.110 Emergency Services

For purposes of determining compliance with Section 65 of the Act, timely determination shall mean a determination is made within 30 days after the health care plan receives a claim for emergency services if no additional information is needed to determine the emergency services meet the definition of an emergency medical condition. In the event additional information is necessary to make such a determination, the health care plan shall request the medical record documenting the presenting symptoms at the time care was sought within 15 days after receipt of the emergency services claim and make a determination within 30 days after its receipt.

Section 5420.120 Post Stabilization Services

For purposes of determining compliance with Section 70 of the Act, timely determination shall mean a determination is made within 30 days after the health care plan receives a claim for post stabilization services if no additional information is needed to determine that services rendered were not contrary to the instructions of the health care plan or its delegated health care provider if the contact was made between those parties and the treating health care provider prior to the services being rendered. In the event additional information is necessary to make such a determination, the health care plan shall request the medical record documenting the time, phone number dialed, and the result of the communication for request for authorization of post stabilization medical services as well as the post stabilization medical services rendered within 15 days after receipt of the post stabilization services claim and make a determination within 30 days after its receipt

Section 5420.130 Registration of Utilization Review Organizations

a) Registration: On or after July 1, 2000, a utilization review organization may not conduct utilization review for persons subject to Section 85 of the Managed Care Reform and Patient Rights Act [215 ILCS 134/85] unless the utilization review organization has registered with the Director. An application for registration shall be in a format as set forth in Exhibit D of this Part, and must be signed by an officer or director of the utilization review organization. Initial registration applications shall be deemed approved unless the Director finds such application to be noncompliant with either the standards set forth in Section 85 of the Managed Care Reform and Patient Rights Act or this Part.

b) Fees: A utilization review organization must register with the Director every two years. A fee of $3,000 must be submitted with each application or renewal unless the utilization review organization is accredited by the Health Utilization Medical Standards of the American Accreditation Healthcare Commission (URAC), the National Committee for Quality Assurance (NCQA), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in which case the fee is $1500.

c) Any material changes in the information filed pursuant to this Part shall be filed with the Director within 30 days after such change. Loss of accreditation status will require re-registration and payment of a $3000 fee pursuant to subsections (a) and (b) of this Section.

d) Renewals and Appeals:

1) A registered utilization review organization may continue to operate, if the application and fee have been filed 30 days prior to the renewal date, until the renewal is denied or issued by the Director.

2) If the renewal application and fee are not received prior to the renewal date, the registration will automatically expire and the utilization review organization must re-register and pay a fee pursuant to subsection (a) and (b) of this Section.

3) If an application for registration or renewal is denied under this Part, the applicant may appeal such denial by requesting a hearing under the terms of Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100/10-5 through 10-70] and 50 Ill. Adm. Code 2402. A petition for

hearing must be postmarked no later than 30 days from the date of initial denial. A hearing shall be scheduled within 45 days after the petition is filed with the Director. A decision by the Director shall be rendered within 60 days after the close of the hearing.

(Source: New Section added at 24 Ill. Reg. 9429, effective July 1, 2000)

Section 5420.140 Operational Requirements

A Utilization Review Organization shall comply with all URAC standards except where specifically addressed by Section 45 and 50 of the Act for health care plans. The terms in Section 45 and 50 of the Act shall have the meaning assigned by the Act. Utilization review decisions shall be issued pursuant to the Managed Care Reform and Patient Rights Act [215 ILCS 134/1 through 299].

(Source: New Section added at 24 Ill. Reg. 9429, effective July 1, 2000)

Section 5420.Exhibit A Description of Coverage - Cover Page

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

What emergency room visits will be paid for by your health care plan.

How specialists (both in and out of network) can be accessed.

How to file complaints and appeal health care plan decisions (including external independent reviews).

How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at_____. (Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

Section 5420.Exhibit B Description of Coverage - Worksheet

Plan:
Name:
Address:
Toll Free Telephone Number:
Web site (optional)

			Description of Coverage		
Basics	**Your Doctor** *(description of process for selection of physician, PCP and/or WPHCP)*				
	Annual Deductible (if applicable)				
	Out-of-Pocket Maximum	***Individual***			
		Family			
	Lifetime Maximums (if applicable)				
	Preexisting Condition Limitations				
			Description Of Coverage	**Health Care Plan Covers**	**You Pay**
In the Hospital	**Number of Days of Inpatient Care**				
	Room & Board				
	Surgeon's Fees				
	Doctor's Visits				
	Medications				
	Other Miscellaneous Charges				
Emergency Care	**Emergency Services -** *(medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.)*				
	Emergency Post-stabilization services				
In the Doctor's Office	**Doctor's Office Visits**				
	Routine Physical Exams				
	Diagnostic Tests and X-rays				
	Immunizations				
	Allergy Treatment & Testing				
	Wellness Care				
Medical Services	**Outpatient Surgery**				
	Maternity Care	***Hospital Care***			
		Physician Care			
	Infertility Services				
	Mental Health	***Outpatient***			

		Inpatient			
	Substance Abuse	***Outpatient***			
		Inpatient			
	Outpatient Rehabilitation Services				
Other Services*	**Durable Medical Equipment**				
	Hospice				
	Home Health Care				
	Prescription Drugs				
	Dental Services				
	Vision Care				

*Copayments and deductibles for these services may not apply to your out of pocket maximums.

Service Area (Boldface Type)

[A summary description of the area to be served by the health care plan.]

Exclusions and Limitations (Boldface Type)

[A summary description of all contract exclusions, exceptions and limitations.]

Pre-certification and Utilization Review (Boldface Type)

[A summary description of the procedures and requirements for pre-certification and other utilization review procedures.]

Emergency Care (Boldface Type)

[A summary description of requirements for and coverage of pre and post emergency care.]

Primary Care Physician Selection (Boldface Type)

[A summary description of procedures and requirements for primary care physician selection.]

Access to Specialty Care (Boldface Type)

[A summary description of referral policies, including standing referrals, and any limitation on access to specialists. This should include access to, and limitations on access to, out of network specialists.]

Out-of-Area Coverage (Boldface Type)

[A summary description of benefits available to the enrollee for out-of-area coverage.]

Financial Responsibility (Boldface Type)

[A summary description to the enrollee of all out-of-pocket expenses, including copayments, deductibles and premiums payable under the policy. When the entire premium is not paid directly by the enrollee, then the enrollee may need to contact the benefit administrator for the level of contribution.]

Continuity of Treatment (Boldface Type)

[A summary description of the health care plan's provision for continuity of treatment in the event that the enrollee's health care provider terminates from the plan during a course of care, including time frames for requesting transitional services.]

Appeals Process (Boldface Type)

[A summary description of the process for health care service appeals, complaints, external independent reviews, administrative complaints and utilization review complaints, including time frames and a phone number to call to receive more information from the health care plan concerning the enrollee's appeal process.]

Any enrollee not satisfied with the health care plan's resolution of any complaint may appeal the final plan decision to the Department of Insurance, through the Consumer Services Section, at one of the following locations:

320 West Washington Street
Springfield, Illinois 62767-0001

OR

100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601-3251

You may also contact the Department electronically at *http://www.state.il.us/ins.*

Note: External grievance determinations in most cases are not appealable through the Department of Insurance.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

Section 5420.Exhibit C Complaint Record and Column Descriptions

COMPLAINT RECORD

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H
Health Care Plan ID	Complaint Origin	Function Code	Date Received	Date Closed	IDOI Complain	External Review	Disposition

EXPLANATION

1. Column A. Identification Number - This is the identification number used by the health care plan to identify the complaint internally.

2. Column B. Complaint Origin - complaint was filed by:

   a) Consumer or enrollee;
   b) Provider;
   c). Any other individual.

3. Column C. Function Code. Complaints are to be classified by function(s) or the health care plan involved as follows:

   a) Denial of care or treatment;
   b) Denial of diagnostic procedure;
   c) Denial of referral request;
   d) Sufficient choice and accessibility of health care providers;
   e) Underwriting;
   f) Marketing and sales;
   g) Claims and utilization review;
   h) Member services;
   i) Provider relations;
   j) Miscellaneous.

4. Column D. Date Received - date received by the health care plan.

5. Column E. Date Closed - date closed by the health care plan.

6. Column F. Insurance Department Complaint - If the complaint was also sent to the health care plan from the Department, the health care plan should provide the IDOI complaint number in this column.

7. Column G. External Review-indicate by placing an “X” in the column if complaint was processed through external review procedure.

8. Column H. Disposition -

a) Relief Granted - If the complaint was resolved in favor of the complainant;
b) Partial Relief Granted-If the complaint was only partially resolved in favor of the complainant;
c) Information Furnished-The complaint did not require action only information to be provided to the enrollee;
d) No Relief Granted - If the complaint was not resolved in favor of the complainant.

Section 5420.Exhibit D Application for Registration of a Utilization Review Organization

1. Name of Applicant _____

Type of Applicant (check one):

___ Corporation
___ Partnership
___ Limited Liability Corporation
___ Other (Describe) _____

FEI Number _____

Contact Person _____
Business Telephone Number ( ) _____
Fax Number ( ) _____
Email Address _____

2. Type of Utilization Review Organization (check one):

___ Health Care Utilization
___ Comprehensive Utilization Review
___ Specialty Utilization Review

Check **all** categories that apply (as applicable):

___ Licensed HMO providing utilization review services outside of the HMO
___ Licensed HMO providing utilization review services only within that HMO
___ Third Party Administrator
___ Licensed insurance company providing utilization review services outside of that insurance company
___ Licensed Insurance Company providing utilization review services only within that insurance company
___ Hospital or medical group providing utilization review services for other than internal purposes
___ Other (Describe) _____

3. Business Address
Street (do not use PO Box) _____
City _____ State _____ Zip _____

4. Mailing Address
Street or P.O. Box _____
City _____ State _____ Zip _____

5. Business Telephone Number (___)_____
Toll Free Number (___)_____
FAX Number (___)_____
Email Address/Website _____

6. Agent for Service of Process in Illinois

Name _____
Street Address (do not use P.O. Box) _____
City _____ State _____ Zip _____

7. For each Utilization Review Program supply the following information:

a) The name, address, telephone number and normal business hours of the utilization programs.

b) The organization and governing structure of the utilization review programs.

c) The number of lives for which utilization review is conducted by each utilization program.

d) Hours of operation of each utilization review program.

e) Description of the grievance process for each utilization program.

f) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

g) Written policies and procedures for protecting confidential information according to applicable State and Federal laws for each utilization review program.

h) Biographical information for organization officers and directors as set forth in Exhibit E of this Part. Biographical affidavits shall be stamped “confidential” by the utilization review organization.

8. Indicate accreditation status below.

a) ___ Accredited by:
___ URAC
___ NCQA
___ JCAHO

b) ___ Unaccredited.

9. Affirmation (to be signed by an officer or director of the utilization review organization only):

I, _____ do hereby certify that
(typed name, title)

_____
(utilization review organization)

complies with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards, and do hereby affirm that all of the information presented in this application is true and correct.

_____ _____
(signature) (date)

(Source: New Section added at 24 Ill. Reg. 9429, effective July 1, 2000)

Section 5420.Exhibit E Utilization Review Organization Officers and Directors Biographical Affidavit

Full name and address of company (do not use group names)

In connection with the above-named company, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) **If answer is "No" or "None," so state.**

1. Affiant's full name (initials not acceptable)

2a. Have you ever had your name changed?_____ If yes, give the reason for the change. _____

2b. Give other names used at any time

3. Affiant's Social Security #

4. Date and place of birth

5. Affiant's business address

Business Telephone #

6. List your residences for the last ten (10) years starting with your current address, giving:

Date	Address	City and State

7. Education: List dates, names, locations and degrees

College:

Graduate Studies:

Others:

8. List memberships in Professional Societies and Associations

9. Present or proposed position with the applicant company

10. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past twenty (20) years, giving:

Dates	Employer and Address	Title

Please circle one:

11. May present employer be contacted? Yes No May former employers be contacted? Yes No

12a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____

12b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? _____ If yes, give details.

(OVER)

13. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date, license issued, issuer of license, date terminated, reasons for termination.)

_____

14. During the last ten (10) years, have you ever been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____If yes, give details.

_____

15. List any administrators, insurers or HMOs in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power). _____

If any of the stock is pledged or hypothecated in any way, give details. _____

_____

16. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant administrator or its affiliates? _____ If any of the shares of stock are pledged or hypothecated in any way, give details. _____

_____

17. Have you ever been adjudged bankrupt? _____

18. Have you ever been convicted or had a sentence imposed or suspended or had pronouncement of a sentence suspended or been pardoned for conviction of or pleaded guilty or nolo contendere to any information or an indictment charging any felony, or charging a misdemeanor involving embezzlement, theft, larceny, or mail fraud, or charging a violation of any corporate securities statute or any insurance law, or have you been the subject of any disciplinary proceedings of any federal or state regulatory agency? _____If yes, give details.

_____

19. Has any company been so charged, allegedly as a result of any action or conduct on your part? _____ If yes, give details. _____

_____

20. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any insurer, HMO or administrator which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship? _____

21. Has the certificate of authority or license to do business of any insurance company or registration of any administrator of which you were an officer or director or key management person ever been suspended, revoked or denied while you occupied such position? _____ If yes, give details.

_____

Declaration

Dated and signed this _____ day of _____ at _____.
I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____

State of _____

County of _____

Personally appeared before me the above named _____
personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____
(Notary Public)

(SEAL)

My commission expires _____.

Important Notice: Disclosure of this information is **required** under Illinois Departmental Rules.

(Source: New Section added at 24 Ill. Reg._____effective July 1, 2000)